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Research Article

Awareness and Attitudes Towards Violence and Abuse among Emergency Nurses

Ok-Hee Cho, RN, PhD, [1] Kyeong-Sook Cha, RN, PhD, [2] Yang-Sook Yoo, RN, PhD [3,*]

[1] Department of Nursing, College of Nursing and Health, Kongju National University, Kongju, South Korea
[2] Department of Nursing Science, Sun Moon University, Asan, South Korea
[3] College of Nursing, The Catholic University of Korea, Seoul, South Korea

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SUMMARY

Purpose: This study identifies degree of awareness and legal knowledge about overall abuse and violence, and investigates attitudes towards domestic violence in emergency nurses.
Methods: The data collection period was between August and December 2012 for 131 nurses who worked in the emergency center of five hospitals in South Korea. This study surveyed emergency nurses about the recognition of abuse and violence, the legal knowledge of abuse and violence, and the attitudes towards domestic violence.
Results: This study showed that approximately 60.0% of participants experienced incidents of suspected abuse or violence, but the reporting rates were low. Of all the participants, 70.2% knew that they must report the discovery of abuse or violent incidents, but 45.0% did not know that if someone who had duty to report but did not report that he/she had a legal responsibility. Most emergency nurses agreed that "even if the domestic violence is severe it should not be suggested to victims that they run away, leaving children at home", and "perpetrators are patients who need treatment."
Conclusions: Appropriate awareness about abuse and violence, and systematic education are required for emergency nurses so that they can provide appropriate interventions.

Rapid industrialization, urbanization, and modernization with the improvement of living standards changed traditional values, and had seen a greater number of patriarchal and extended families transform into nuclear families. As a result, the function of the family and the idea of respecting the elderly have weakened, which led to a change in social structure. Because of this, the risk of neglect, abandonment, physical and emotional threat, and abuse of elderly people and children has increased [1]. Along with an increase in violence in society, the incidence of domestic violence also increased. The degree of damage caused by violence is serious: the claim has been raised that domestic violence has to be acknowledged as a societal problem, rather than be treated as a personal or family matter that has been overlooked or concealed, and solutions should be implemented at the government level [2].

Most of the victims of violence and abuse involve women, children, and elderly at home or in community facilities. Throughout society, abuse occurs in the form of various types of physical, emotional, sexual abuse, and neglect. Considering domestic violence and the abuse of children, there was a higher incidence of physical abuse than emotional abuse [3], but regarding the abuse of elderly people, there was a greater incidence of emotional abuse than physical abuse [4]. Violence or abuse that occurs in the home is not limited to a single incident, but is repeated continuously [5]. Over time, the patterns and frequency of violence become more serious, and victims have to return to their homes, which are the places where the violence or abuse occur [3,6]. These incidents of violence and abuse cause emotional and physical damage such as depression and anxiety. Therefore, victims require medical intervention, and many women who are assaulted receive medical treatment in emergency room (ER). According to the Korean Ministry of Gender Equality and Family [3], 30.1% of women received medical treatment related to domestic violence, and 9.4% of women received medical treatment for psychological symptoms. Some of these victims receive medical treatment in the emergency room. At that stage, the emergency nurse should provide medical treatment to these victims of abuse or violence as well

* Correspondence to: Yang-Sook Yoo, RN, PhD, College of Nursing, The Catholic University of Korea, 222 Banpo-daero, Seocho-gu, Seoul 06591, South Korea.
E-mail address: ysyoo@catholic.ac.kr

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as possess professional skills to detect the signs of abuse or assault, and then, provide the appropriate legal services.

In Korea, domestic violence is still considered a private matter; it is solely the focus of medical treatment, and not considered a serious social or legal issue [5,7]. According to the Department of Health and Human Services report, amongst personnel with a duty to report, domestic violence has low rate of reporting, with only 2.2% of child abuse incidents [8] and 10.2% of elderly abuse incidents reported by medical professionals [4]. In sexual assault cases, the collection of forensic evidence while providing initial treatment is necessary, and it has been reported that there is a lack of awareness regarding the importance of and knowledge about providing these types of legal services [9]. In addition, although the hospital is the initial place for aid, victims of sexual violence often face unpredicted negative experiences there, such as neglect or criticism from medical professionals [10]. Some medical professionals think that the inappropriate behavior of the victim caused the incidence of sexual abuse [11]. When the victim of sexual abuse talks about the incident or requires the relevant services, the medical professional shows negative attitudes such as skepticism or criticism. As such, medical professionals who behave negatively cannot adequately provide the necessary medical services to the victim, or interfere with the process of collecting forensic evidence [12]. To improve their awareness, appropriate education and training are required.

Many victims of abuse or violence seek emergency treatment for physical injury, and the ER staff has a high probability of examining the victims of abuse or violence, as well as the legal and professional responsibility to report the incident. Among clinical staff, nurses are the first to make contact with patients and their families, and keep close relationships with patients. The emergency nurses should have the knowledge and skills of emergency care, as well as evaluate the precise circumstances of outpatients, and determine cases of physical, sexual, or violent abuse and injury [13]. Thus, it is important to increase the awareness and knowledge of this abuse so that nurses can provide appropriate medical, nursing, and legal services to victims.

In Korea, the field of nursing research on abuse and violence is primarily focused on the victim's experience or mental condition [14], or cases in which nurses on duty were the victims of violence [15–17]. Nurses were the participants of some studies about the awareness of elderly abuse [18] or child abuse [19,20]. However, emergency nurses have not yet been the participants of a study on the degree of awareness of overall abuse or violence.

In this study, emergency nurses required to perform a professional duty in reporting abuse and violence, were used as participants to identify degree of awareness and legal knowledge about overall abuse and violence, as well as to investigate their attitudes towards domestic violence. Therefore, this study provides the baseline data, based on which an educational program or guideline for nurses can be developed to correctly identify abusive or violent situations and provide effective intervention.

Methods

Study design

This study used a descriptive method to identify the awareness and attitudes of emergency room nurses towards abuse and violence.

Samples and setting

Convenience sampling was used, and participants were nurses who worked in the emergency center of five hospitals that had more than 500 beds, located in Seoul and Gyeonggi-do. The minimum number of participants required for this study, using a two-tailed significance level of 0.05, effect size of 0.3, and power of 0.08 (using the G*Power 3.1 program) was calculated to be 128 people [21]. Considering failure rate, the survey was distributed to 150 people, and 137 surveys were returned (returned ratio: 91.4%). Among these, six incomplete responses were excluded, and 131 people (failure ratio: 8.6%) were the final participants.

Ethical consideration

The content and methods of this study were approved by the institutional review board in the Catholic University of Korea (CUMC11U069). All of the participants were provided with information about the purpose and process of the study, their rights to refuse participation at any point without disadvantage, and the voluntary nature of participation, and written consent was obtained. Once all of the data had been collected, all participants received a small gift.

Instruments

Participant characteristics

Participant characteristics including age, gender, religious affiliation, education level, marital status, nurse's clinical experience, ER work experience, position, experience with police reports, usage of the sexual assault evidence collection kit, and the need for nurse specialist who is dedicated to treating sexual assault were investigated.

Awareness of abuse and violence

Sixteen questions were developed by the researcher as a tool used to measure the recognition of abuse and violence, based on previous studies [18,19,22]. The content validity of the preliminary questions was examined by professional groups composed of one specialist from the Department of Emergency Medicine, two emergency nurses, and two professors in nursing; an 80.0% agreement was reached on all questionnaires.

This tool measured educational experience and practical experience over the previous year in areas of elderly abuse, child abuse, sexual abuse, and domestic violence for each area of the training experience, and whether suspicious situations were reported and the reason for not reporting.

Legal knowledge about abuse and violence

Jung's [22] elderly abuse and legal knowledge evaluation questionnaire was modified and used as a tool to measure the legal knowledge of abuse and violence. The content validity of the questions was examined by professional groups composed of one specialist from the Department of Emergency Medicine, two emergency nurses, and two professors in nursing; an 80.0% agreement was reached on all questionnaires.

This tool consisted of seven questions about the duties and procedures of reporting abuse and violence, and the penalties and roles of a protection agency. For each question, participants can answer “yes”, “no”, and “not sure”. Cronbach α values of tool reliability for Jung [22] were .76 and in this study, .78.

Attitudes towards domestic violence

Twenty-five questions developed by Lee et al [7] were used as a tool to measure attitudes towards domestic violence. This tool consists of attitudes towards victims (5 questions), attitudes towards offenders (13 questions), and attitudes towards children (7 questions) in relation to incidents of domestic violence. Each question can be answered with “yes” or “no”. In this study, the

reliability of the tools using the Kuder-Richardson Formula-20 tools was 0.79.

Data collection

The data collection period was between August and December 2012. Researchers visited the hospital personally, received permission from the nursing department, explained the purpose of the research to participants, and then collected the survey after the participant had completed it. It took approximately 20 minutes to complete the survey.

Data analysis

The general characteristics of the participants were presented as a frequency, percentage, mean, and standard deviation, and emergency nurses' awareness of abuse and violence, legal knowledge, and attitudes towards domestic violence were presented as a frequency and percentage.

Results

Participant characteristics

The mean age of the participants was 28.1 years old, and 88.6% (116 people) were women. Additionally, 51.2% (67 people) were affiliated to a religion, and 77.9% (102 people) did not have a spouse. Nurses with more than 60 months of clinical experience numbered 40.4% (53 people), and 41.2% (54 people) had 13–35 months of working experience in the ER. Among participants, 90.1% (118 people) were staff nurses. Participants who had experience of reporting incidents to police caused by "patients riots" were 51.9% (68 people), which was the highest rate of reporting. "Dead on arrival" and "rape victim" were each reported by 13.0% (17 people). Regarding the sexual assault evidence collection kit, 28.2% answered that they "heard about it, but [did] not know how to use it," and 22.9% (30 people) answered that they "[did] not know about it" (Table 1).

Table 1 *General Characteristics of Participants (N = 131).*

Characteristics	Frequency (%) or *M* ± *SD*
Age (yr)	28.1 ± 4.9
Gender	
Female	116 (88.6)
Male	15 (11.4)
Religion	
Yes	67 (51.2)
No	64 (48.8)
Spouse	
Yes	29 (22.1)
No	102 (77.9)
Total clinical career (months)	
≤ 12	12 (9.2)
13–35	45 (34.4)
36–59	21 (16.0)
≥ 60	53 (40.4)
Emergency department career (months)	
≤ 12	23 (17.6)
13–35	54 (41.2)
36–59	18 (13.7)
≥ 60	36 (27.5)
Position	
Staff nurse	118 (90.1)
Head and charge nurse	13 (9.9)
Experience of reporting to police (*n* = 117)	
Patients riots	68 (51.9)
Dead on arrival	17 (13.0)
Reporting of sexual abuse	17 (13.0)
Elderly, child abuse victim report	15 (11.5)
Sexual abuse evidence collection kit	
Know about it	64 (48.9)
Have heard about it but does not know how to use	37 (28.2)
Do not know about it	30 (22.9)
Need of sexual assault nurse specialist	
Really need it	14 (10.7)
Need it	86 (65.7)
Do not need it	13 (9.9)
Not sure	18 (13.7)

Awareness of abuse and violence

Suspected abuse and violence cases that "were not reported" were the highest for elderly abuse and domestic violence were 57.3%; unreported sexual abuse cases were 54.1%, and unreported child abuse was 53.4%. The reasons for not reporting abuse and violence were most commonly cited as "it was not severe and did not have sufficient evidence," further nurses reported that they "do not know where or how to report," or "because of heavy workload, there is no time to report abuse or violence," and they did not report because "it was considered a personal or family matter".

Education experience in relation to abuse and violence was the highest for sexual abuse (61.8%), child abuse (50.4%), elderly abuse (40.5%), and domestic violence (32.1%). The most accessible information for the last year was about sexual abuse (57.3%) (Table 2).

Table 2 *Awareness about Abuse and Violence (N = 131).*

Category	Elderly abuse	Child abuse	Sexual assault	Domestic violence
	Frequency (%)			
Reporting of suspected case				
Yes	7 (5.4)	14 (10.7)	9 (6.9)	10 (7.6)
No	75 (57.3)	70 (53.4)	71 (54.1)	75 (57.3)
N/A	49 (37.3)	47 (35.9)	51 (39.0)	46 (35.1)
Reason for not reporting[a]				
Not severe/insufficient evidence	34 (26.0)	31 (23.7)	27 (20.7)	30 (22.9)
Do not know where or how to report	11 (8.4)	13 (10.1)	13 (10.1)	11 (8.4)
Current workload is too heavy to be concerned about abuse or violence	13 (10.1)	11 (8.4)	10 (7.6)	11 (8.4)
Personal and family matter	8 (6.2)	9 (6.9)	10 (7.6)	11 (8.4)
No result from reporting	3 (2.3)	3 (2.3)	3 (2.3)	3 (2.3)
Inconvenient to report	0 (0.0)	0 (0.0)	0 (0.0)	2 (1.6)
Education experience regarding abuse or violence				
Yes	53 (40.5)	66 (50.4)	81 (61.8)	42 (32.1)
No	78 (59.5)	65 (49.6)	50 (38.2)	89 (67.9)
Exposure to related issues over past year (TV/radio, newspaper, internet etc.) experience				
A high amount of exposure	50 (38.2)	55 (42.0)	75 (57.3)	61 (46.6)
Regular amount of exposure	40 (30.5)	46 (35.1)	33 (25.2)	40 (30.5)
Not exposed at all	41 (31.3)	30 (22.9)	23 (17.5)	30 (22.9)

[a] Excluding negative (absent) answers.

Legal knowledge regarding abuse and violence

Among the participants, 70.2% of the participants knew that they must report the discovery of abuse or violent incidents, but 45.0% did not know that if someone who had duty to report did not report, he/she had a legal responsibility. Among the participants, 67.2% said that someone who had a duty to report, also had a legal responsibility to report when they discover abuse or violence

Table 3 *Legal Knowledge Regarding Abuse and Violence (N = 131).*

Item	Yes	No	Do not know
	Frequency (%)		
Medical professionals (nurses, doctors) have a duty to report abuse or violence.	101 (77.1)	10 (7.6)	20 (15.3)
The perpetrator of abuse or violence has to serve prison sentence or pay a fine.	67 (51.2)	19 (14.5)	45 (34.3)
If anyone discovers abuse or violence, then must they report it?	92 (70.2)	12 (9.2)	27 (20.6)
If the personnel who have duty to report do not report then they are legally responsible.	56 (42.8)	16 (12.2)	59 (45.0)
If the personnel who have a duty to report find out about the abuse and violence at work, then they have responsibility to report it.	88 (67.2)	11 (8.4)	32 (24.4)
Do you know a reporting organization for victims of abuse and violence?	61 (46.5)	–	70 (53.5)
Do you know the phone number to report to when you discover victims of abuse and violence?	52 (39.7)	–	79 (60.3)

committed to a patient, but 53.5% did not know where to report, and 60.3% did not know the phone number to report to (Table 3).

Attitudes towards domestic violence

One of the attitudes towards victim of domestic violence was that, "Even if the domestic violence [was] serious, it should not be suggested that victims run away, leaving children at home," and 77.1% people answered "yes" to this. However, more participants answered "no" than "yes" to the following statements: "People who have been hurt act in a way to deserve that" (65.6%); "If an offender repents, then the victim has to forgive and reconcile" (86.3%); "If the victim prays, the offender will change for the better" (87.0%); and "Even though domestic violence is severe, the victim has to be patient and continue to live with the offender for the sake of their children" (86.3%).

One of the attitudes towards perpetrators of domestic violence was that more participants answered "yes" rather than "no" to the following statements: "The perpetrators of domestic violence need to receive treatment" (89.3%); "The cause of domestic violence is not seeing a spouse as an equal partner" (84.7%); "The perpetrator can recover by receiving counseling and treatment" (71.0%).

The majority of participants answered "no" to the following statements: "Fighting with a spouse is the same as cutting water with a knife" (84.7%); "A third party cannot be involved in domestic violence" (87.0%); "If you are stressed, you can beat your spouse" (89.3%); "The perpetrator loves the victim and is trying to change the victim using violence, to live together" (90.8%); "Because domestic violence is inherited genetically, it cannot be treated" (90.8%); "Well-educated people do not use violence" (95.4%); "Women and pollack needed to be beaten by every three days" (97.7%); and "Sexual interaction after domestic violence is a sign of reconciliation" (97.7%).

Participants believed that, when compared to normal children, children who experienced domestic violence "exhibit more antisocial behavior" (96.2%), had "a higher tendency to use violence to resolve any disputes" (95.4%), "a higher rate of distrust and higher degree of anger" (96.2%), "a higher level of maladjustment at school" (95.4%), "a higher degree of anxiety or depression" (94.7%), and a "higher likelihood to use violence against a spouse when they grow up" (80.2%); more people answered "yes" to these statements than "no" (Table 4).

Discussion

The result of this study showed that approximately 60.0% of participants experienced incidents of suspected abuse or violence, but the reporting rates were low. From Jung's [22] research, the report rate of personnel with duty to report was 11.3% for elderly abuse. Of this, 0.0% of reports were made by nurses. The National Senior Protection Agency collected reports from personnel with a duty to report. Of these reported incidents, 10.2% were reported by medical professionals, and it was a markedly low reporting rate

Table 4 *Attitudes towards Domestic Violence (N = 131).*

Item	Yes	No
	Frequency (%)	
Attitudes toward victims		
Even if the domestic violence is serious, it should not be suggested that victims run away, leaving children at home.	101 (77.1)	30 (22.9)
People who have been hurt act in a way to deserve that.	45 (34.4)	86 (65.6)
If an offender repents, then the victim has to forgive and reconcile.	18 (13.7)	113 (86.3)
If the victim prays, the offender will change for the better.	17 (13.0)	114 (87.0)
Even though domestic violence is severe, the victim has to be patient and continue to live with the offender for the sake of their children.	18 (13.7)	113 (86.3)
Attitudes toward perpetrators		
The perpetrators of domestic violence need to receive treatment.	117 (89.3)	14 (10.7)
The cause of domestic violence is not seeing a spouse as an equal partner.	111 (84.7)	20 (15.3)
The perpetrator can recover by receiving counseling and treatment.	93 (71.0)	38 (29.0)
The perpetrator engages in domestic violence because of job loss or poverty.	72 (55.0)	59 (45.0)
The perpetrator uses violence against their spouse to show their strength.	65 (49.6)	66 (50.4)
Fighting with a spouse is the same as cutting water with a knife.	20 (15.3)	111 (84.7)
A third party cannot be involved in domestic violence.	17 (13.0)	114 (87.0)
If you are stressed, you can beat your spouse.	14 (10.7)	117 (89.3)
The perpetrator loves the victim and is trying to change the victim using violence, to live together.	12 (9.2)	119 (90.8)
Because domestic violence is inherited genetically, it cannot be treated.	12 (9.2)	119 (90.8)
Well-educated people do not use violence.	6 (4.6)	125 (95.4)
Women and pollack needed to be beaten by every 3 days.	3 (2.3)	128 (97.7)
Sexual interaction after domestic violence is a sign of reconciliation.	3 (2.3)	128 (97.7)
Attitudes toward children of domestic violence		
Children who experienced domestic violence exhibit more antisocial behavior than normal children do.	126 (96.2)	5 (3.8)
Children who experienced domestic violence have a higher tendency to use violence to resolve any disputes.	125 (95.4)	6 (4.6)
Children who experienced domestic violence have a higher rate of distrust and higher degree of anger.	126 (96.2)	5 (3.8)
Children who experienced domestic violence have a higher level of maladjustment at school.	125 (95.4)	6 (4.6)
Children who experienced domestic violence have a higher degree of anxiety or depression.	124 (94.7)	7 (5.3)
Children who experienced domestic violence have a higher likelihood to use violence against a spouse when they grow up.	105 (80.2)	26 (19.8)
There is no difference between children who have experienced domestic violence and children who have not.	44 (33.6)	87 (66.4)

compared to welfare social workers (47.2%) and the employees of elderly welfare facilities (33.0%) [4].

Regarding child abuse in 2012, 36.9% of the suspected child abuse incidence were reported by personnel with a duty to report, but only 0.9% of those were medical professionals [23], from Kim and Park's [24] research, the reporting rate for child abuse was 5.5%. This is considerably low, compared to the United States, where medical professionals reported 8.2% of all reported incidents [25], and doctors reported 73.0% of incidents when child abuse was suspected [26]. It is difficult to directly compare these studies, because each is affected by the medical professionals' department, region, and the types and sizes of clinics and facilities. However, it is evident that most medical professionals do not report when they suspect abuse and violence, because their reporting rate is low. "It is not a severe degree of abuse and there is insufficient evidence" was the most common answer, followed by "do not know where to report or the procedure to report." This result is consistent with previous research indicating that personnel with a duty to report do not report because they are not confident or do not have sufficient evidence of abuse [22,24,27], as well as a lack of awareness about the reporting procedure [22,24]. For domestic violence cases, the second biggest reason for not reporting the incident was that they "do not want to be involved in a personal or family matter" (20.0%). This is similar to the result that suggested the obstacle to assess domestic violence was the protection of personal information and privacy issues [28].

Additionally, residents and family medicine specialists [7,29] who cited that they "do not want to be involved in a personal or family matter" were high, at 40.0% and 39.4%, respectively. This shows that many of the health professionals view domestic violence as a personal or private family matter. Furthermore, they have a tendency to ignore it, which is the same as the attitude of the public, and will thus benefit from continuous media promotion to improve the social awareness of domestic violence.

Currently, to increase the awareness related to abuse and violence, nationwide campaigns were implemented at the government level; for medical professionals, there are lectures or seminars and employee education provided by related organizations [4,22]. Nurses have a higher chance of being the first professionals in contact with victims of abuse and violence. They should thus be able to identify victims of abuse and violence. Furthermore, they play an important role in discontinuing the cycle of abuse and violence [30].

The result of this research shows that 61.8% of participants received training related to sexual abuse, whereas training related to elderly abuse was 40.5%, domestic violence was 32.1%, and overall training was lower than 50.0%. In Korea, there are continuous promotional activities to increase the awareness of sexual assault, which highlight the importance of processes such as evidence collection. Additionally, to increase the reporting rate of sexual assault, as well as provide professional medical service to victims of sexual assault, medical manuals and sexual assault evidence collection kits have been developed and provided [31]. However, in this study, more than 50.0% of participants did not know about the kits, or how to use them; this caused difficulties in collecting and confirming evidence. Nurses, who interact with victims of abuse or violence need to determine facts. Also, they should have the skills to confirm the evidence and take appropriate intervention actions. In previous studies [32], it was suggested that a high-risk group be included in the emergency patient record to identify abuse and violence more precisely. Thus, there should be appropriate education provided to medical professionals, including emergency nurses, to identify abuse and violence at an early stage, and a professional and structured educational program using practical cases of various types of abuse that outline the types of abuse and violence.

In this research, 77.1% of emergency nurses knew that a medical professional has a duty to report incidents of abuse or violence. In fact, 67.2% stated that "if personnel who have the duty to report during work learned about abuse or violence, then they have to report." However, participants who answered that they do not know where to report, or the phone number to report to, were up to 53.5% and 60.3%, respectively. In previous research, 58.7%–75.4% of Korean nurses [24,29] were aware of the fact that they have a duty to report child abuse, but 39.7% of nurses working in the pediatric department or ER [24] and 91.6% of nurses working at large hospitals [29] did not know about the procedure to report or the agencies to report to. Compared to the awareness among nurses about their duty to report abuse or violence, the availability of information, such as the reporting to police, was low. The lack of reporting despite an increase of social interest and the continuous promotion of awareness through the media about the seriousness of abuse and violence shows that reporting does not occur because of a lack of education regarding the procedure of reporting and the legal responsibility of medical professionals.

According to previous studies [19,33,34], if personnel perceive that it is their role to report abuse they have a higher chance of reporting than those who do not perceive it as their role. In addition, it induces a high reporting rate if promotional advertisements or the phone number of an abuse-reporting center is posted in the department [35]. Thus, to increase medical professionals' awareness of their duty to report and increase the reporting rate, a systematic education of guidelines or rules related to abuse or violence and a user board easily accessible by medical professionals to post related information should be in place.

In this research, most emergency nurses agreed that "even if the domestic violence is severe it should not be suggested to victims that they run away, leaving children at home." This differed from cases where family doctors agreed with the statement of, "If perpetrators repent, then victims need to forgive and reconcile with them" [7]. This result might be attributed to gender stereotypes, as 88.6% of the nursing participants of this study were women, in comparison to 74.7% men who were doctors in family medicine [7]. Results from this study agreed with those of previous research [36], which suggested that the healthcare workers' personal belief and the stereotypical ideology of the society affected the awareness of spousal abuse.

The most common attitudes toward perpetrators were that "perpetrators are patients who needed treatment" and "perpetrators can get recovery with counseling and treatment." This was consistent with those from previous research [7] in which many medical professionals perceived that the perpetrator of domestic violence had mental or moral disorders that caused them to exhibit violence, and counseling or therapy could be useful for the correction of violent behavior.

In conclusion, our study results show that the emergency nurses' rates of reporting abuse and violence are low.

The emergency nurses have to give up their prejudiced attitude toward the victim, act as personnel with a duty to report, and recognize the seriousness of the abuse and violence. Additionally, emergency nurses should be educated in providing professional intervention to both victims and perpetrators. The intervention of an emergency medical practitioner can be the only method to stop repeated exposure of victims to violent situations. Therefore, medical professional working in the ER should examine the possibility of abuse or violence for all outpatients, and provide appropriate interventions [37]. To perform these roles appropriately, it is important that they use easily accessible materials to

assess the abuse or violence, develop guidelines and implement systematic education.

This study was limited by the location of the participants. Thus, it is difficult to generalize the research findings. Additionally, situations of abuse or violence were studied using a survey, rather than collecting observational data. As such, further studies need to be conducted with more participants.

Conclusion

Through this study, emergency nurses' attitudes toward abuse and violence were identified. More than half of the participants came into contact with victims of suspected abuse or violence. Thus, medical professionals have to provide physical, psychological, and legal interventions to both victims and perpetrators, but it is difficult because of the lack of knowledge for intervention to them. The results of this study showed that many emergency nurses had insufficient knowledge regarding the sexual assault evidence collection kit, as well as limited educational experience on issues of violence and abuse. In addition, many nurses were not aware of the fact that they may be held legally responsible for failure to report violence and abuse, and to which institutions such reports are to be made. Therefore, appropriate awareness about abuse and violence, and systematic education are required for emergency nurses so that they can provide appropriate interventions. To achieve this, it is necessary to provide short-term training programs, and develop and perform continual, organization-wide job training. Furthermore, to improve the awareness of abuse and violence amongst all nurses, including emergency nurses, training needs to extend to the undergraduate curriculum. Further research is required to develop the appropriate assessment tool and maintenance guidelines, to use it in various situations.

Conflicts of interest

The authors declare no conflict of interest.

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